NICE National Institute for Health and Care Excellence

NICE quality standard

Antenatal care

Quality standard

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Contents

This standard is based on NG3, PH27, PH11, CG110, NG201 and NG209.

This standard should be read in conjunction with QS3, QS15, QS65, QS83, QS82, QS92, QS98, QS69, QS60, QS46, QS37, QS35, QS32, QS43, QS67, QS73, QS75, QS94, QS105, QS109 and QS115.

Quality statements

Statement 1 Pregnant women are supported to access antenatal care, ideally by 10 weeks 0 days.

Statement 2 Pregnant women are cared for by a named midwife throughout their pregnancy.

Statement 3 Pregnant women have a complete record of the minimum set of antenatal test results in their maternity notes.

Statement 4 Pregnant women with a body mass index of 30 kg/m^2 or more at the booking appointment are offered personalised advice from an appropriately trained person on healthy eating and physical activity.

Statement 5 Pregnant women who smoke are referred for evidence-based stop-smoking support at the booking appointment.

Statement 6 Pregnant women are offered testing for gestational diabetes if they are identified as at risk of gestational diabetes at the booking appointment.

Statement 7 Risk assessment – pre-eclampsia. This statement has been removed. For more details see update information.

Statement 8 Pregnant women at risk of venous thromboembolism at the booking appointment are referred to an obstetrician for further management.

Statement 9 Risk assessment – high risk of venous thromboembolism. This statement has been merged with statement 8. For more details see update information.

Statement 10 Pregnant women are offered fetal anomaly screening in accordance with current UK National Screening Committee programmes.

Statement 11 Pregnant women with an uncomplicated singleton breech presentation at 36 weeks or later (until labour begins) who prefer cephalic vaginal birth are offered external cephalic version.

Statement 12 Fetal wellbeing – membrane sweeping for prolonged pregnancy. This statement has been moved to the NICE quality standard on inducing labour. For more details see update information.

Quality statement 1: Services – access to antenatal care

Quality statement

Pregnant women are supported to access antenatal care, ideally by 10 weeks 0 days.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

a) Evidence of local services that ensure antenatal care is readily and easily accessible.

Data source: Local data collection. The baseline assessment tool for NICE's guideline on pregnancy and complex social factors can be used to assess current activity related to recording information for women presenting to antenatal care with complex social needs to inform mapping of the local population and to guide service provision.

b) Evidence of local arrangements to encourage pregnant women to access and maintain contact with antenatal care services.

Data source: Local data collection. The baseline assessment tool for NICE's guideline on pregnancy and complex social factors can be used to assess current activity related to recording information for women presenting to antenatal care with complex social needs to inform mapping of the local population and to guide service provision.

Process

Proportion of pregnant women missing a scheduled antenatal appointment who are followed up within locally defined timescales.

Numerator – the number in the denominator followed up within locally defined timescales.

Denominator – the number of pregnant women missing a scheduled antenatal appointment.

Data source: Local data collection.

Outcome

a) Pregnant women accessing antenatal care who are seen for booking by 10 weeks 0 days.

Data source: The NHS Digital Maternity Services Data Set collects data on booking appointment dates and estimated dates of delivery. The Care Quality Commission Maternity Services Survey asks the question 'Roughly how many weeks pregnant were you when you had your 'booking' appointment (the appointment where you were given access to your pregnancy notes)?'.

b) Pregnant women accessing antenatal care who are seen for booking by 12 weeks 6 days.

Data source: The NHS Digital Maternity Services Data Set collects data on booking appointment dates and estimated dates of delivery. The Care Quality Commission Maternity Services Survey asks the question 'Roughly how many weeks pregnant were you when you had your 'booking' appointment (the appointment where you were given access to your pregnancy notes)?'.

c) Pregnant women accessing antenatal care who are seen for booking by 20 weeks 0 days.

Data source: The NHS Digital Maternity Services Data Set collects data on booking appointment dates and estimated dates of delivery. The Care Quality Commission Maternity Services Survey asks the question 'Roughly how many weeks pregnant were you when you had your 'booking' appointment (the appointment where you were given access to your pregnancy notes)?'.

d) Median gestation at booking.

Data source: The NHS Digital Maternity Services Data Set collects data on booking appointment dates and estimated dates of delivery. The Care Quality Commission Maternity Services Survey asks the question 'Roughly how many weeks pregnant were you when you had your 'booking' appointment (the appointment where you were given access to your pregnancy notes)?'.

e) Pregnant women accessing antenatal care attend at least the recommended number of antenatal appointments.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers ensure that systems are in place to support pregnant women to access antenatal care, ideally by 10 weeks 0 days.

Health and social care professionals support pregnant women to access antenatal care, ideally by 10 weeks 0 days. This includes following up women who have missed a scheduled antenatal appointment.

Commissioners ensure that they commission services that are readily and easily accessible and that support pregnant women to access antenatal care, ideally by 10 weeks 0 days.

Pregnant women are encouraged to see a healthcare professional about their pregnancy as early as possible and have regular check-ups from their midwife or doctor throughout their pregnancy (antenatal care). This may include being contacted by their midwife or doctor if they miss a check-up.

Source guidance

- Antenatal care. NICE guideline NG201 (2021), recommendations 1.1.1, 1.1.4, 1.1.7, 1.1.8, 1.3.7, and 1.3.8

- Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors. NICE guideline CG110 (2010), recommendations 1.1.1, 1.1.2 (key priorities for implementation) and 1.2.8

Definitions of terms used in this quality statement

Support to access antenatal care

Commissioners and providers should ensure that antenatal care can be started in a variety of straightforward ways, depending on women's needs and circumstances, for example, by self-referral, referral by a GP, midwife or another healthcare professional or through a school nurse, community centre or refugee hostel.

At the first antenatal (booking) appointment, discuss antenatal care with the woman (and her partner) and provide her schedule of antenatal appointments (plan 10 routine antenatal appointments with a midwife or doctor for nulliparous women and 7 for parous women).

At the first antenatal (booking) appointment (and later if appropriate), discuss and give information on:

- what antenatal care involves and why it is important
- the planned number of antenatal appointments
- where antenatal appointments will take place
- which healthcare professionals will be involved in antenatal appointments
- how to contact the midwifery team for non-urgent advice
- how to contact the maternity service about urgent concerns, such as pain and bleeding.

[NICE's guideline on antenatal care, recommendations 1.1.1, 1.1.7, 1.1.8, 1.3.7 and 1.3.8]

Follow-up after a missed appointment may be undertaken by the maternity service or other community-based service the woman is in contact with, such as a children's centre, addiction service or GP. Follow-up should be via a method of contact that is appropriate to the woman, which may include:

- text message
- letter
- telephone
- community or home visit.

[NICE's guideline on pregnancy and complex social factors, recommendation 1.2.8 and expert opinion]

Equality and diversity considerations

Pregnant women include women with complex social needs who may be less likely to access or maintain contact with antenatal care services. Examples of women with complex social needs include, but are not limited to, women who:

- have a history of substance misuse (alcohol and/or drugs)
- have recently arrived as a migrant, asylum seeker or refugee
- have difficulty speaking or understanding English
- are aged under 20
- have experienced domestic abuse
- are living in poverty
- are homeless.

It is therefore appropriate that localities give special consideration to these groups of women within the measures. NICE's guideline on pregnancy and complex social factors has recommendations about how to make antenatal care accessible to pregnant women with complex social needs and how to encourage women to maintain ongoing contact with maternity services.

Quality statement 2: Services – continuity of care

Quality statement

Pregnant women are cared for by a named midwife throughout their pregnancy.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

a) Evidence of local arrangements and audit to ensure that pregnant women are cared for by a named midwife throughout their pregnancy.

Data source: Local data collection.

b) Evidence of local arrangements to ensure that systems are in place to coordinate a pregnant woman's care should her named midwife not be available.

Data source: Local data collection.

Process

Proportion of pregnant women with a named midwife.

Numerator – the number in the denominator with a named midwife.

Denominator – the number of pregnant women accessing antenatal care.

Data source: Local data collection.

Outcome

Pregnant women's satisfaction with the continuity of their antenatal care.

Data source: Local data collection. The Care Quality Commission Maternity Services Survey asks the question 'At your antenatal check-ups, did you see the same midwife every time?'

What the quality statement means for different audiences

Service providers ensure that systems are in place to enable pregnant women to be cared for by a named midwife throughout their pregnancy.

Healthcare professionals follow local systems and guidance to provide continuity of care to pregnant women through the provision of a named midwife.

Commissioners ensure they commission services that enable pregnant women to be cared for by a named midwife throughout their pregnancy.

Pregnant women are cared for a by a named midwife throughout their pregnancy.

Source guidance

Antenatal care. NICE guideline NG201 (2021), recommendation 1.1.12

Definitions of terms used in this quality statement

Named midwife

Having continuity of carer means that a trusting relationship can be developed between the woman and the healthcare professional who cares for her. The Better Births report by the National Maternity Review defines continuity of carer as consistency in the midwifery team (between 4 and 8 individuals) that provides care for the woman and her baby throughout pregnancy, labour and the postnatal period. A named midwife coordinates the care and takes responsibility for ensuring that the needs of the woman and her baby are

met throughout the antenatal, intrapartum and postnatal periods. [NICE's guideline on antenatal care, terms used in this guideline]

Quality statement 3: Services – record keeping

Quality statement

Pregnant women have a complete record of the minimum set of antenatal test results in their maternity notes.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

a) Evidence of local arrangements to ensure that pregnant women have a complete record of the minimum set of antenatal test results in their maternity notes.

Data source: Local data collection.

b) Evidence of local audit to monitor the completeness and accuracy of antenatal test results in women's maternity notes.

Data source: Local data collection.

Process

Proportion of pregnant women accessing antenatal care who have a complete record of the minimum set of antenatal test results in their maternity notes, appropriate to their stage of pregnancy.

Numerator – the number in the denominator with a complete record of the minimum set of antenatal test results in their maternity notes, appropriate to their stage of pregnancy.

Denominator – the number of pregnant women accessing antenatal care.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers ensure that systems are in place to maintain a complete record of the minimum set of antenatal test results in women's maternity notes.

Healthcare professionals ensure that women have a complete record of the minimum set of antenatal test results in their maternity notes.

Commissioners ensure that they commission services that maintain a complete record of the minimum set of antenatal test results in women's maternity notes.

Pregnant women are given a complete record of the minimum set of their antenatal test results in their maternity notes.

Source guidance

- Antenatal care. NICE guideline NG201 (2021), recommendation 1.2.11
- Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors. NICE guideline CG110 (2010), recommendation 1.1.10

Definitions of terms used in this quality statement

Minimum set of antenatal test results

Table 1 minimum set of tests for routine scheduled antenatal care

Investigation	Timing
Blood pressure	All routine appointments

Investigation	Timing
Urine dipstick test for proteinuria	All routine appointments
Full blood count, blood group and rhesus D status	At booking or first scan if booking appointment was not face to face
Height, weight and body mass index	At booking or first scan if booking appointment was not face to face
Sickle cell and thalassaemia screen	At booking
Hepatitis B virus screen	At booking
HIV screen	At booking
Syphilis screen	At booking
Ultrasound scan to determine gestational age and detect multiple pregnancy	Between 11 weeks 2 days and 14 weeks 1 day
Screen for Down's syndrome, Edward's syndrome and Patau's syndrome	Offer at booking Ultrasound scan between 11 weeks 2 days and 14 weeks 1 day
Ultrasound screen for fetal anomalies	Offer at booking Between 18 weeks 0 days and 20 weeks 6 days
Measure of symphysis fundal height	All routine appointments after 24 weeks 0 days
Full blood count, blood group and antibodies	At 28 weeks
Abdominal palpation to identify possible breech presentation	All routine appointments from 36 weeks 0 days

Note that women should be able to make an informed choice about whether to accept or decline each test, and notes should include a record of any tests offered and declined as well as the results of tests accepted. [NICE's guideline on antenatal care, schedule of antenatal appointments]

Equality and diversity considerations

Maternity notes and the information within them should be accessible to all women, including women who do not speak or read English and those with additional needs such as physical, sensory or learning disabilities.

Women should be able to choose whether to have all the results of their antenatal tests documented in their maternity notes. This may be particularly important when information is sensitive (for example, positive screening results for HIV, hepatitis B virus and syphilis). Where a woman declines to have antenatal test results documented in her maternity notes, the results should instead be recorded within other medical notes. It is therefore appropriate that localities give special consideration to these groups of women within the measures. NICE's guideline on pregnancy and complex social factors has recommendations about how to make antenatal care accessible to pregnant women with complex social needs and how to encourage women to maintain ongoing contact with maternity services.

Quality statement 4: Risk assessment – body mass index

Quality statement

Pregnant women with a body mass index of 30 kg/m^2 or more at the booking appointment are offered personalised advice from an appropriately trained person on healthy eating and physical activity.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

a) Evidence of local arrangements to offer pregnant women the option to have their body mass index calculated and recorded at the booking appointment.

Data source: Local data collection.

b) Evidence of local arrangements to ensure that pregnant women with a body mass index of 30 kg/m^2 or more at the booking appointment are offered personalised advice from an appropriately trained person on healthy eating and physical activity.

Data source: Local data collection. The self-assessment tool for NICE's guideline on weight management before, during and after pregnancy.

Process

a) Proportion of pregnant women accessing antenatal care whose body mass index is calculated and recorded at the booking appointment.

Numerator – the number in the denominator whose body mass index is recorded at the booking appointment.

Denominator – the number of pregnant women accessing antenatal care.

Data source: The NHS Digital Maternity Services Data Set collects data on the BMI of the mother at booking. Areas may wish to consider setting a local target that reflects expectations that some women may decide not to have their body mass index calculated.

b) Proportion of pregnant women with a body mass index of 30 kg/m^2 or more at the booking appointment who are offered personalised advice from an appropriately trained person on healthy eating and physical activity.

Numerator – the number in the denominator offered personalised advice from an appropriately trained person on healthy eating and physical activity.

Denominator – the number of pregnant women with a body mass index of 30 kg/m^2 or more at the booking appointment.

Data source: Local data collection. The NHS Digital Maternity Services Data Set collects data on the BMI of the mother at booking.

Outcome

Women with a body mass index of 30 kg/m^2 or more feel confident to make decisions about healthy eating and physical activity during their pregnancy.

Data source: Local data collection, for example, local survey.

What the quality statement means for different audiences

Service providers ensure that systems are in place to offer pregnant women with a body mass index of 30 kg/m^2 or more at the booking appointment personalised advice from an appropriately trained person on healthy eating and physical activity.

Healthcare professionals offer women with a body mass index of 30 kg/m^2 or more at the

booking appointment personalised advice on healthy eating and physical activity or, if they are not appropriately trained to do this, refer them to an appropriately trained person.

Commissioners ensure they commission services that offer pregnant women with a body mass index of 30 kg/m^2 or more at the booking appointment personalised advice from an appropriately trained person on healthy eating and physical activity.

Pregnant women with a body mass index of 30 kg/m^2 or more at the booking appointment are offered advice relevant to them from an appropriately trained person on healthy eating and physical activity.

Source guidance

- Antenatal care. NICE guideline NG201 (2021), recommendations 1.2.12 and 1.3.9
- Maternal and child nutrition. NICE guideline PH11 (2008), recommendation 6
- Weight management before, during and after pregnancy. NICE guideline PH27 (2010), recommendation 2

Definitions of terms used in this quality statement

An appropriately trained person

Someone who can demonstrate expertise and competencies in weight management in pregnancy, including providing advice about nutrition and/or physical activity. This may include obstetricians, GPs, midwives, health visitors, nurses, dietitians, midwifery assistants, support workers and those working in weight management programmes (commercial or voluntary). [Expert opinion]

Equality and diversity considerations

The body mass index threshold may need adapting for different groups of pregnant women (for example, women from certain ethnic groups). A body mass index measure is considered unsuitable for use with those under 18.

Quality statement 5: Risk assessment – smoking cessation

Quality statement

Pregnant women who smoke are referred for evidence-based stop-smoking support at the booking appointment.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

a) Evidence of local arrangements that pregnant women have their smoking status recorded at the booking appointment.

Data source:NHS Digital's Maternity Services Data Set collects data on smoking status at the booking appointment.

b) Evidence of local arrangements to ensure that pregnant women who smoke are referred for evidence-based stop-smoking support.

Data source: Local data collection.

c) Evidence of local arrangements to ensure that pregnant women who smoke and opt out of attending evidence-based stop-smoking support receive follow-up.

Data source: Local data collection.

Process

a) Proportion of pregnant women accessing antenatal care whose smoking status is recorded at the booking appointment.

Numerator – the number in the denominator whose smoking status is recorded at the booking appointment.

Denominator – the number of pregnant women accessing antenatal care.

Data source:NHS Digital's Maternity Services Data Set collects data on smoking status at the booking appointment.

b) Proportion of pregnant women who smoke who are referred for evidence-based stop-smoking support at the booking appointment.

Numerator – the number in the denominator who are referred for evidence-based stop-smoking support.

Denominator – the number of pregnant women who smoke and attend a booking appointment.

Data source: Local data collection.

c) Proportion of pregnant women who smoke and opt out of attending evidence-based stop-smoking support who receive follow-up.

Numerator – the number in the denominator who receive follow-up.

Denominator – the number of pregnant women who smoke and opt out of attending evidence-based stop-smoking support.

Data source: Local data collection.

Outcome

a) Quit rates for pregnant women.

Data source: Local data collection. NHS Digital's statistics on NHS Stop Smoking Services in England includes quit rates for pregnant women who set a quit date.

b) Smoking rates in pregnancy.

Data source:NHS Digital Statistics on women's smoking status at time of delivery: England collects data on smoking status at the time of delivery.

What the quality statement means for different audiences

Service providers ensure that systems are in place to ensure that all pregnant women who smoke are referred for evidence-based stop-smoking support at their booking appointment.

Healthcare professionals refer all pregnant women who smoke for evidence-based stop-smoking support at their booking appointment.

Commissioners ensure they commission services that refer all pregnant women who smoke for evidence-based stop-smoking support at their booking appointment.

Pregnant womenwho smoke are referred for evidence-based stop-smoking support at their booking appointment.

Source guidance

Tobacco: preventing uptake, promoting quitting and treating dependence. NICE guideline NG209 (2021), recommendation 1.18.2

Definitions of terms used in this quality statement

Referral for evidence-based stop-smoking support

An opt-out referral to receive stop-smoking support should be provided to all pregnant women who:

- say they smoke or have stopped smoking in the past 2 weeks **or**
- have a carbon monoxide reading of 4 parts per million (ppm) or above **or**
- have previously been provided with an opt-out referral but have not yet engaged with stop-smoking support.

An opt-out referral to receive stop-smoking support should first be provided at the booking appointment and when appropriate throughout the period of antenatal care. The midwife may provide the pregnant woman with information about the risks to the unborn child of smoking when pregnant and the hazards of exposure to secondhand smoke for both mother and baby. [Adapted from NICE's guideline on tobacco, recommendations 1.11.11, 1.18.2 and 1.19.3]

Evidence-based stop-smoking support

Interventions and support to stop smoking, regardless of how services are commissioned or set up.

Stop-smoking support for pregnant women should be intensive and ongoing throughout pregnancy and beyond. The professionals involved may include midwives who have been specially trained to help pregnant women who smoke to quit. [Adapted from NICE's guideline on tobacco, recommendations 1.20.1, 1.23.3 and terms used in this guideline; stop-smoking support]

Quality statement 6: Risk assessment – gestational diabetes

Quality statement

Pregnant women are offered testing for gestational diabetes if they are identified as at risk of gestational diabetes at the booking appointment.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

a) Evidence of local arrangements to ensure that pregnant women have their risk factors for gestational diabetes identified and recorded at the booking appointment.

Data source: Local data collection.

b) Evidence of local arrangements to ensure that pregnant women identified as at risk of gestational diabetes at the booking appointment are offered testing for gestational diabetes.

Data source: Local data collection.

Process

a) Proportion of pregnant women identified as at risk of gestational diabetes at the booking appointment who are offered testing for gestational diabetes.

Numerator – the number in the denominator offered testing for gestational diabetes.

Denominator – the number of pregnant women identified as at risk of gestational diabetes at the booking appointment.

Data source: Local data collection.

b) Proportion of pregnant women identified as at risk of gestational diabetes at the booking appointment who receive testing for gestational diabetes.

Numerator – the number of women in the denominator receiving testing for gestational diabetes.

Denominator – the number of pregnant women identified as at risk of gestational diabetes at the booking appointment.

Data source: Local data collection.

Outcome

Early identification of women with gestational diabetes.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers ensure that systems are in place to offer pregnant women identified as at risk of gestational diabetes at the booking appointment testing for gestational diabetes.

Healthcare professionals offer pregnant women identified as at risk of gestational diabetes at the booking appointment testing for gestational diabetes.

Commissioners ensure they commission services that offer pregnant women identified as at risk of gestational diabetes at the booking appointment testing for gestational diabetes.

Pregnant womenwith a higher than normal chance of developing gestational diabetes (a type of diabetes that occurs during pregnancy) at the booking appointment are offered a test for gestational diabetes.

Source guidance

- Antenatal care. NICE guideline NG201 (2021), recommendations 1.2.21 and 1.2.22
- Diabetes in pregnancy: management from preconception to the postnatal period. NICE guideline NG3 (2015, updated 2020), recommendations 1.2.1 to 1.2.7

Definitions of terms used in this quality statement

At risk of gestational diabetes

Risk factors are:

- body mass index above 30 kg/m^2
- previous macrosomic baby weighing 4.5 kg or more
- previous gestational diabetes
- family history of diabetes (first-degree relative with diabetes)
- an ethnicity with a high prevalence of diabetes.

Women with any of these risk factors should be offered testing for gestational diabetes. [NICE's guideline on diabetes in pregnancy, recommendation 1.2.2]

Testing for gestational diabetes

Use the 75-g 2-hour oral glucose tolerance test (OGTT) to test for gestational diabetes in women with risk factors.

Offer women who have had gestational diabetes in a previous pregnancy:

- early self-monitoring of blood glucose **or**
- a 75-g 2-hour OGTT as soon as possible after booking (whether in the first or second trimester), and a further 75-g 2-hour OGTT at 24–28 weeks if the results of the first OGTT are normal.

Offer women with any of the other risk factors for gestational diabetes a 75-g 2-hour OGTT at 24–28 weeks. [NICE's guideline on diabetes in pregnancy, recommendations 1.2.5, 1.2.6 and 1.2.7]

Equality and diversity considerations

Any risk assessment for gestational diabetes should be corrected for ethnicity. Some ethnicities are risk factors for diabetes and people from these groups should be offered testing in accordance with the guidance.

Quality statement 7: Risk assessment – pre-eclampsia

This statement has been removed. For more details see update information.

Quality statement 8: Risk assessment – venous thromboembolism

Quality statement

Pregnant women at risk of venous thromboembolism at the booking appointment are referred to an obstetrician for further management.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

a) Evidence of local arrangements to ensure that pregnant women have their risk of venous thromboembolism (VTE) assessed and recorded at the booking appointment.

Data source: Local data collection.

b) Evidence of local arrangements to ensure that pregnant women at risk of VTE at the booking appointment are referred to an obstetrician for further management.

Data source: Local data collection.

Process

a) Proportion of pregnant women accessing antenatal care who have their risk of VTE assessed and recorded at the booking appointment.

Numerator – the number in the denominator who have their risk of VTE assessed and recorded at the booking appointment.

Denominator – the number of pregnant women accessing antenatal care.

Data source: Local data collection.

b) Proportion of pregnant women at risk of VTE at the booking appointment who are referred to an obstetrician for further management.

Numerator – the number in the denominator referred to an obstetrician for further management.

Denominator – the number of pregnant women at risk of VTE at the booking appointment.

Data source: Local data collection.

Outcome

Incidence of VTE in pregnant women.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers ensure that systems are in place to refer pregnant women at risk of VTE at the booking appointment to an obstetrician for further management.

Healthcare professionals refer pregnant women at risk of VTE at the booking appointment to an obstetrician for further management.

Commissioners ensure they commission services which refer pregnant women at risk of VTE at the booking appointment to an obstetrician for further management.

Pregnant womenwho at the time of their booking appointment have a high or moderate chance of developing VTE (a blood clot) are referred to an obstetrician for support.

Source guidance

Antenatal care. NICE guideline NG201 (2021), recommendations 1.2.18 and 1.2.20

Definitions of terms used in this quality statement

At risk of VTE

High risk of VTE is defined as any previous VTE except a single event related to major surgery.

Intermediate risk of VTE is defined as any of the following:

- hospital admission
- single previous VTE related to major surgery
- high-risk thrombophilia and no VTE
- medical comorbidities, for example, cancer, heart failure, active lupus, inflammatory bowel disease, or inflammatory polyarthropathy, nephrotic syndrome, type 1 diabetes mellitus with nephropathy, sickle cell disease, current intravenous drug use
- any surgical procedure, for example, appendicectomy
- ovarian hyperstimulation syndrome (first trimester only).

Or 4 or more risk factors from the following list (or 3 risk factors from 28 weeks):

- obesity (BMI above 30 kg/m^2)
- age above 35 years
- parity 3 or more
- smoking
- gross varicose veins
- current pre-eclampsia

- immobility, for example, paraplegia, pelvic girdle pain with reduced mobility
- family history of unprovoked or oestrogen-provoked VTE in first-degree relative
- low-risk thrombophilia
- multiple pregnancy
- in vitro fertilisation or assisted reproductive technology
- transient risk factors: dehydration/hyperemesis, current systemic infection, long-distance travel.

[Royal College of Obstetricians and Gynaecologists guideline on thrombosis and embolism during pregnancy and the puerperium, appendix 1]

Quality statement 9: Risk assessment – high risk of venous thromboembolism

This statement has been merged with statement 8. For more details see update information.

Quality statement 10: Screening – national fetal anomaly screening programmes

Quality statement

Pregnant women are offered fetal anomaly screening in accordance with current UK National Screening Committee programmes.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local NHS-commissioned services to ensure that all pregnant women are offered fetal anomaly screening in accordance with current UK National Screening Committee programmes.

Data source: Local data collection.

Process

a) Proportion of pregnant women booking before 21 weeks who are offered the NHS fetal anomaly screening programme at the booking appointment.

Numerator – the number in the denominator who are offered the NHS fetal anomaly screening programme.

Denominator – the number of pregnant women accessing antenatal care before 21 weeks.

Data source: Local data collection.

b) Proportion of pregnant women booking before 14 weeks 2 days that agreed to fetal anomaly screening who are offered an ultrasound scan to screen for Down's syndrome, Edward's syndrome and Patau's syndrome to take place between 11 weeks 2 days and 14 weeks 1 day.

Numerator – the number in the denominator who are offered an ultrasound screening for Down's syndrome, Edward's syndrome and Patau's syndrome to take place between 11 weeks 2 days and 14 weeks 1 day.

Denominator – the number of pregnant women booking before 14 weeks 2 days that agreed to fetal anomaly screening for Down's syndrome, Edward's syndrome and Patau's syndrome.

Data source: Public Health England's NHS Fetal Anomaly Screening Programme publishes data on first trimester combined screening for Down's syndrome (T21), Edwards' syndrome (T18) and Patau's syndrome (T13).

c) Proportion of pregnant women booking before 21 weeks that agreed to fetal anomaly screening who are offered ultrasound screening for fetal anomalies to take place between 18 weeks 0 days and 20 weeks 6 days.

Numerator – the number in the denominator offered ultrasound screening for fetal anomalies to take place between 18 weeks 0 days and 20 weeks 6 days.

Denominator – the number of pregnant women booking before 21 weeks that agreed to fetal anomaly screening.

Data source: Public Health England's NHS Fetal Anomaly Screening Programme publishes data on fetal anomaly ultrasound screening.

Outcome

a) Pregnant women feel they have made an informed decision about whether to undergo fetal anomaly screening.

Data source: Local data collection, for example, local survey.

b) Screening uptake rates.

Data source: includes data on screening uptake rates. Public Health England's NHS Fetal Anomaly Screening Programme

What the quality statement means for different audiences

Service providers ensure that systems are in place to offer fetal anomaly screening to pregnant women in accordance with current UK National Screening Committee programmes.

Healthcare professionals offer fetal anomaly screening to pregnant women in accordance with current UK National Screening Committee programmes.

Commissioners ensure they commission services that offer fetal anomaly screening to pregnant women as part of NHS care, in accordance with current UK National Screening Committee programmes.

Pregnant women who access antenatal care before 14 weeks 2 days are offered ultrasound screening for Down's syndrome, Edward's syndrome and Patau's syndrome.

Pregnant womenwho access antenatal care before 21 weeks are offered an ultrasound scan to screen for various conditions in their unborn baby.

Source guidance

- Antenatal care. NICE guideline NG201 (2021), recommendations 1.2.13, 1.2.14, and 1.2.15
- Public Health England. Fetal anomaly screening programme handbook (2021)
- Public Health England. Fetal anomaly screening programme: standards (2021)

Definitions of terms used in this quality statement

Fetal anomaly screening in accordance with current UK National Screening Committee programmes

The UK National Screening Committee recommends all eligible pregnant women in England are offered fetal anomaly screening. The NHS fetal anomaly screening programme has responsibility for implementing this policy.

The combined test uses maternal age, gestational age calculated from the crown-rump length measurement, nuchal translucency measurement, and two biochemical markers of pregnancy - associated plasma protein A and free beta human chorionic gonadotrophin hormone. The optimal time to perform the combined test is between 11 weeks 2 days and 14 weeks 1 day but a maternal blood specimen may be taken from 10 weeks onwards.

For women presenting too late for first trimester testing, the quadruple test (maternal age and four biochemical markers) window runs from 14 weeks 2 days to 20 weeks 0 days.

The fetal anomaly ultrasound scan should be offered to take place between 18 weeks 0 days and 20 weeks 6 days. [Adapted from Public Health England's Fetal anomaly screening programme handbook and Fetal anomaly screening programme: standards]

Equality and diversity considerations

The offer and implications of screening should be understood by all women to enable them to make informed decisions. This will necessitate provision of information in an accessible format (particularly for women with physical, sensory or learning disabilities and women who do not speak or read English).

Quality statement 11: Fetal wellbeing – external cephalic version

Quality statement

Pregnant women with an uncomplicated singleton breech presentation at 36 weeks or later (until labour begins) who prefer cephalic vaginal birth are offered external cephalic version.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

a) Evidence of local arrangements to ensure that pregnant women with a suspected breech presentation at 36 weeks or later (until labour begins) are referred for confirmatory ultrasound assessment.

Data source: Local data collection.

b) Evidence of local arrangements to ensure that pregnant women with a confirmed uncomplicated singleton breech presentation at 36 weeks or later (until labour begins) who prefer cephalic vaginal birth are offered external cephalic version.

Data source: Local data collection.

Process

a) Proportion of pregnant women with a suspected breech presentation at 36 weeks or later (until labour begins) who are referred for confirmatory ultrasound assessment.

Numerator – the number in the denominator referred for confirmatory ultrasound assessment.

Denominator – the number of pregnant women with a suspected breech presentation at 36 weeks or later (until labour begins).

Data source: Local data collection.

b) Proportion of pregnant women with a confirmed uncomplicated singleton breech presentation at 36 weeks or later (until labour begins) who prefer cephalic vaginal birth who are offered external cephalic version.

Numerator – the number in the denominator offered external cephalic version.

Denominator – the number of pregnant women with a confirmed uncomplicated singleton breech presentation at 36 weeks or later (until labour begins) who prefer cephalic vaginal birth.

Data source: Local data collection

Outcome

a) External cephalic version rates.

Data source: Local data collection.

b) Mode of delivery including:

- rates of vaginal birth, emergency and elective caesarean section after successful external cephalic version
- rates of vaginal birth, emergency and elective caesarean section after unsuccessful external cephalic version
- rates of vaginal birth and emergency caesarean section after diagnosis of breech presentation in labour.

Data source: The NHS Digital Maternity Services Data Set collects data on delivery method.

What the quality statement means for different audiences

Service providers ensure that systems are in place to offer pregnant women with an uncomplicated singleton breech presentation at 36 weeks or later (until labour begins) who prefer cephalic vaginal birth external cephalic version.

Healthcare professionals offer pregnant women with an uncomplicated singleton breech presentation at 36 weeks or later (until labour begins) who prefer cephalic vaginal birth external cephalic version.

Commissioners ensure they commission services that offer pregnant women with an uncomplicated singleton breech presentation at 36 weeks or later (until labour begins) who prefer cephalic vaginal birth external cephalic version.

Pregnant women with a single baby in the breech position (bottom first with knees either flexed or extended) but with no other problems at 36 weeks or later in their pregnancy who prefer a vaginal birth are offered external cephalic version (a procedure to move the baby round to the head-down position), which includes first having an ultrasound scan to confirm the baby's position.

Source guidance

- Antenatal care. NICE guideline NG201 (2021), recommendation 1.2.38
- Caesarean birth. NICE guideline NG192 (2021), recommendations 1.2.1 and 1.2.2

Definitions of terms used in this quality statement

Pregnant women who prefer cephalic vaginal birth

For women with an uncomplicated singleton pregnancy with breech presentation confirmed after 36 weeks plus 0 days discuss the different options available and their benefits, risks and implications, including:

- external cephalic version (to turn the baby from bottom to head down)

- breech vaginal birth
- elective caesarean birth.

[NICE's guideline on antenatal care, recommendation 1.2.38]

Equality and diversity considerations

There may be some women whose breech presentation is not identified and who are not offered an external cephalic version.

Quality statement 12: Fetal wellbeing – membrane sweeping for prolonged pregnancy

This statement has been moved to the NICE quality standard on inducing labour. For more details see update information.

Update information

August 2021: Changes were made to align this quality standard with the updated NICE guideline on antenatal care. The wording of statement 3 was amended to reflect that there may also be digital access to maternity notes rather than just hand-held notes. Statements 8 and 9 on risk assessment for venous thromboembolism were merged to reflect the recommendations in the updated guideline that indicate that all pregnant women at risk should be referred to an obstetrician for further management. The wording of statement 11 on external cephalic version was revised to better reflect the wording in the updated guideline. Statement 12 on membrane sweeping for prolonged pregnancy was moved to the NICE quality standard on inducing labour to better align the quality standards with the updated guideline. Measures, data sources, links and references were also updated throughout.

April 2016: The source recommendations and definitions for statement 6 on risk assessment – gestational diabetes have been updated to reflect changes to NICE's guideline on antenatal care for uncomplicated pregnancies in March 2016.

June 2015: This quality standard has been updated to ensure alignment with NICE's guideline on diabetes in pregnancy, which is a development source for this quality standard. The guideline on diabetes in pregnancy was updated in February 2015.

In particular, information in the definitions section of statement 6 on testing for gestational diabetes has been updated.

For more information about the changes to the diabetes in pregnancy guideline, see the update information section in NICE's guideline on diabetes in pregnancy.

July 2013: Quality statement 7: Risk assessment – pre-eclampsia has been removed and is replaced by quality statement 2 in NICE's quality standard on hypertension in pregnancy.

Minor changes since publication

November 2021: Quality statement 5 has been amended to ensure alignment with NICE's guideline on tobacco. The wording of the statement has been amended to reflect the terminology of the guideline. The quality measures, source guidance recommendations and definitions have also been amended to align with this guideline.

December 2020: The definition of risk factors for gestational diabetes used in statement 6 on risk assessment – gestational diabetes has been updated to ensure alignment with NICE's guideline on diabetes in pregnancy. The equality and diversity considerations section for statement 6 has also been updated to align with this guideline.

About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, this may not always be appropriate in practice. Taking account of safety, shared decision-making, choice and professional judgement, desired levels of achievement should be defined locally.

Information about how NICE quality standards are developed is available from the NICE website.

See the list of members of the topic expert group who advised on the original development of this quality standard.

This quality standard has been included in the NICE Pathways on diabetes in pregnancy, tobacco use and antenatal care, which bring together everything we have said on a topic in an interactive flowchart.

NICE has produced a quality standard service improvement template to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE guidance and quality standards apply in England and Wales. Decisions on how they apply in Scotland and Northern Ireland are made by the Scottish government and Northern Ireland Executive. NICE quality standards may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

Resource impact

NICE quality standards should be achievable by local services. The potential resource impact is considered by the quality standards advisory committee, drawing on resource impact work for the source guidance. Organisations are encouraged to use the resource impact products for the source guidance to help estimate local costs:

- resource impact statement for NICE's guideline on antenatal care
- financial planning tool for NICE's guideline on weight management before, during and after pregnancy
- resource impact statement for NICE's guideline on diabetes in pregnancy
- resource impact statement for NICE's guideline on caesarean birth
- resource impact report and template for NICE's guideline on tobacco.

Diversity, equality and language

Equality issues were considered during development and equality assessments for this quality standard are available. Any specific issues identified during development of the quality statements are highlighted in each statement.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

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Endorsing organisation

This quality standard has been endorsed by NHS England, as required by the Health and Social Care Act (2012)

Supporting organisations

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- Royal College of Midwives
- Royal College of Nursing (RCN)
- Royal College of Obstetricians and Gynaecologists